Healthy Connections

South Carolina Department of Health and Human Services

Additional Information Required

You recently applied for Medicaid with the State of South Carolina. The application you submitted did not capture all of the information that we need to make a decision. To complete your application, please fill out and return this form within 30 days of the date listed below. Answer the following questions as completely as possible as they apply to you and/or the persons for whom you are applying. The applicants included on this addendum must match the applicants on your original application.

Date: _____ **Form must be returned by:** _____

Primary Applicant Information

Please complete this form for the primary applicant. The name and Person ID have been completed for you.

First name, Middle name, Last name, & Suffix _____ Person ID _____

Please provide answers on this page for the person indicated.

1. **Does this person plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES. If yes, please answer questions a–c. ☐ NO. If no, SKIP to question c.

a. Will this person file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse: _____

b. Will this person claim any dependents on his/her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents: _____

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

2. Was this person in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

3. Does this person pay for things that can be deducted on an income tax return? Check all income deductions that apply and give the amount and frequency.

Alimony paid $ _____

Student loan interest $ _____

Other deductions $ _____

Deduction	Amount	How often?	Start date	End date
_____	$ _____	_____	_____	_____
_____	$ _____	_____	_____	_____
_____	$ _____	_____	_____	_____
_____	$ _____	_____	_____	_____

NEED HELP WITH THIS APPLICATION? Visit SCDHHS.gov or call us at **1-888-549-0820**. Para obtener una copia de este formulario en Español, llame **1-888-549-0820**. If you need help in a language other than English, call **1-888-549-0820** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-800-753-8583**.

Additional Household Member Information

You must complete this section for each additional household member. The name and Person ID have been completed for you. Please provide answers on this page for the person indicated.

First name, Middle name, Last name, & Suffix | Person ID

1. **Does this person plan to file a federal income tax return NEXT YEAR?**
(You can still apply for health insurance even if you don't file a federal income tax return.)

☐ YES. If yes, please answer questions a–c. ☐ NO. If no, SKIP to question c.

a. Will this person file jointly with a spouse? ☐ Yes ☐ No

If yes, name of spouse:

b. Will this person claim any dependents on his/her tax return? ☐ Yes ☐ No

If yes, list name(s) of dependents:

c. Will this person be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

If yes, please list the name of the tax filer: _____

How are you related to the tax filer? _____

2. Was this person in foster care in South Carolina at age 18 or older? ☐ Yes ☐ No

3. Does this person pay for things that can be deducted on an income tax return? Check all income deductions that apply and give the amount and frequency.

Alimony paid $ _____

Student loan interest $ _____

Other deductions $ _____

Deduction	Amount	How often?	Start date	End date
	$			
	$			
	$			
	$			

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Rights and Responsibilities

Please read the following rights and responsibilities. If you disagree with a statement, your eligibility for programs may be impacted.

1. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, or disability. I can file a complaint of discrimination by contacting SCDHHS at (803) 898-2605 and filing a written Civil Rights Discrimination Complaint with the Office for Civil Rights, SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206.
2. I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and may not have to cooperate.
3. I assign and give my rights to any payments from a liable third party to the SCDHHS up to the payment amount that Healthy Connections has made for my medical care. This assignment applies to any of my minor children who may be injured. These payments may include payments from health insurance, legal settlements, or other third parties. I also understand that I have a duty to cooperate in identifying and providing information to assist Healthy Connections in pursuing third parties who may be liable to pay for care and services.
4. I understand that I must cooperate fully with state and federal workers if my case is reviewed. I also understand that, as a condition of eligibility, I must apply for and take steps to obtain any other benefits, including but not limited to, annuities, pensions, retirement, disability and other benefits.
5. As an applicant/beneficiary for Medicaid services, I understand that there are two groups of people that are affected by estate recovery:
   - A person of any age who was a patient in a nursing facility, intermediate care facility for the intellectually disabled, or other medical institution at the time of death, and who was required to pay most of his/her income for the cost of care; or
   - A person who was 55 years of age or older when he/she received medical assistance consisting of nursing facility services, home and community based services, and hospital and prescription drug services provided to individuals in nursing facilities or receiving home community-based services.

   I understand that upon receiving any of these services, the Department of Health and Human Services will file a claim against my estate (all personal and real property owned by me at my death) for the amount Medicaid has paid for my services.
6. I know that I must tell SCDHHS if any information I listed on this application changes and is different than what I wrote on this application. I understand that a change in my information could affect the eligibility for member(s) of my household.
7. The information I provide on this application and in future interaction with SCDHHS will be used to check my eligibility for help paying for health coverage, if I choose to apply. If the information I provide doesn't match our electronic data, I may be asked to send proof. I know that, unless I specifically ask to be excluded, information collected will be securely stored in order to be sure that services provided to my family and me are sufficient and necessary.
8. If I think SCDHHS, the agency that administers Healthy Connections, the state's Medicaid and CHIP programs, has made an error I can appeal its decision. To appeal means to tell someone at SCDHHS that I think the action is wrong, and ask for a fair review of the action. I must submit a written request for such a hearing to SCDHHS. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.
9. I know that personal health information I provide or that is later gathered by SCDHHS is covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I will receive a Notice of Privacy Practices along with my Healthy Connections Card(s).

Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No

I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not,

_____ is incarcerated.

Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow Medicaid or the Health Insurance Marketplace to use income data, including information from tax returns. Medicaid will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next:

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative, you may sign here, as long as you have provided the information required on DHHS Form 1282 - Authorized Representative.
By signing, I state that I have read and agree to the rights and responsibilities stated on this application.

Signature _____ Date (mm/dd/yyyy) _____

Please print this form, then sign it on the line above before submitting.

Mail your signed application to:

SCDHHS - Central Mail
PO Box 100101
Columbia SC 29202-3101

If you want to register to vote, you can complete a voter registration form at **scvotes.org**.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

أذا كانت لغتك الاساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجانا.اتصل على الرقم:

888-549-0280(رقم هاتف الصم والبكم 1-888-842-3620)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့်၊ ကျိာ်အတၱ်မၤစၢၤလၢ တလာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው: 1-888-842-3620).

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် င့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ် ဆိုပါ။